



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

TWELVE OAKS MEDICAL CENTER  
c/o HOLLOWAY & GUMBERT  
3701 KIRBY DRIVE, SUITE 1288  
HOUSTON TX 77098-3926

**Carrier's Austin Representative Box**  
#21

#### **Respondent Name**

LUMBERMENS MUTUAL CASUALTY CO

#### **MFDR Date Received**

SEPTEMBER 12, 2006

#### **MFDR Tracking Number**

M4-07-0288-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary as stated on the table of disputed services:** "IC failed to pay per DWC Rule 134.401...claim pays @ 75% of total charges as charges exceed \$40,000.00 stop-loss threshold. IC further failed to audit according to DWC Rule 134.401(c) (6) (A) (v)."

**Amount in Dispute:** \$92,754.66

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary dated June 28, 2012:** "...MFDR is seeking information regarding the informal contract between Lumbermens Mutual Casualty Company and Twelve Oaks Medical Center. Lumbermens Mutual Casualty Company maintains that there has never been an Informal/Voluntary network contract with Twelve Oaks Medical Center on the dates of service at issue. Further...no reduction of reimbursement was made..."

**Respondent's Supplemental Position Summary dated April 15, 2013:** "Please allow this correspondence to serve as the Carrier's supplemental response.....The Requestor billed \$156,244.41...September 12, 2005 through September 17, 2005. Respondent reimbursed \$24,425.50... As evidenced by the EOBs, the Respondent reimbursed the Requestor according to applicable fee schedule allowance. The applicable fee schedule allowance is a per diem amount for the length of the hospital stay...nowhere in any of the submitted documentation does the Requestor indicate the services were unusually extensive or costly or anything other than routine...In the instant case...the patient underwent the surgery in two phases, which the surgeon indicated in his operative reports were well tolerated...No evidence submitted by the provider explains the particular complexity of the procedure performed...The Requestor has provided no justification how the *admission involved unusually costly or extensive services*. The medical records submitted show routine and expected treatment rendered, the costs of which are provided for in the Texas Per Diem amount..."

**Responses Submitted by:** Thornton, Biechlin, Segrato, Reynolds and Guerra, L.C.

## SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 12 through 17, 2005	Inpatient Hospital Services	\$92,754.66	\$0.00

## FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital for the date of admission in dispute.
  - Effective July 13, 2008, the Division's rule at former 28 Tex. Admin. Code § 134.401 was repealed. The repeal adoption preamble specified, in pertinent part: "Section 134.401 will continue to apply to reimbursements related to admissions prior to March 1, 2008." 33 *TexReg* 5319, 5220 (July 4, 2008). Former 28 Tex. Admin. Code § 134.401(a) (1) specified, in pertinent part: "This guidelines shall become effective August 1, 1997. The Acute Care Inpatient Hospital Fee Guideline (ACIHFG) is applicable for all reasonable and medically necessary medical and/or surgical inpatient services rendered after the Effective Date of this rule in an acute care hospital to injured workers under the Texas Workers' Compensation Act." 22 *TexReg* 6264, 6306 (July 4, 1997).

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### Explanation of Benefits

- W1(45) – workers compensation state fee schedule adjustment
- W4 (900) – based on further review, no additional allowance is warranted
- 885-999 review of this code has resulted in an adjusted reimbursement
- 870 – personal items not covered

### Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Is the requestor entitled to additional reimbursement?

### Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c) (6) (A) (i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds the audited charges equal \$156,244.41. The division concludes that the total audited charges exceed \$40,000.
2. The requestor in its position statement asserts that "claim pays @ 75% of total charges as charges exceed \$40,000.00 stop-loss threshold." The requestor presumes that it is entitled to the stop loss method of payment because the audited charges exceed \$40,000. As noted above, the Third Court of Appeals in its November 13, 2008 opinion rendered judgment to the contrary. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved...unusually extensive services." The requestor failed to discuss or demonstrate that the particulars of the admission in dispute constitute unusually extensive services; therefore, the division finds that the requestor did not meet 28 TAC §134.401(c) (6).
3. In regards to whether the services were unusually costly, the requestor presumes that because the bill exceeds \$40,000, the stop loss method of payment should apply. The Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must **demonstrate** that an admission involved unusually costly services thereby affirming 28 Texas Administrative Code §134.401(c)(6) which states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor failed to discuss the particulars of the admission in dispute that constitute unusually costly services; therefore, the division finds that the requestor failed to meet 28 TAC §134.401(c) (6).
4. 28 Texas Administrative Code §134.401(b)(2)(A) titled General Information states, in pertinent part, that "The basic reimbursement for acute care hospital inpatient services rendered shall be the lesser of:
  - (i) a rate for workers' compensation cases pre-negotiated between the carrier and the hospital;
  - (ii) the hospital's usual and customary charges; and
  - (iii) reimbursement as set out in section (c) of this section for that admission

In the respondent's position summary, the respondent states, "Lumbermens Mutual Casualty Company maintains that there has never been an Informal/Voluntary network contract with Twelve oaks Medical Center on the dates of service at issue." Therefore 28 Texas Administrative Code §134.401(b) (2) (A) (i) does not apply.

In regards to the hospital's usual and customary charges in this case, review of the medical bill finds that the health care provider's usual and customary charges equal \$65,726.00.

In regards to reimbursement set out in (c), the division determined that the requestor failed to support that the services in dispute are eligible for the stop-loss method of reimbursement; therefore 28 Texas Administrative Code §134.401(c)(1) titled Standard Per Diem Amount and §134.401(c)(4) titled Additional Reimbursements, apply. The division notes that additional reimbursements under §134.401(c) (4) apply only to bills that do not reach the stop-loss threshold described in subsection (c) (6) of this section. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c) (1) titled *Standard Per Diem Amount* and §134.401(c) (4) titled *Additional Reimbursements*. The division notes that additional reimbursements under §134.401(c) (4) apply only to bills that do not reach the stop-loss threshold described in subsection (c) (6) of this section.

- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c) (3) (ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission..." The length of stay was five days. The surgical per diem rate of \$1,118.00 multiplied by the length of stay of five days results in an allowable amount of \$5,590.00.
- 28 Texas Administrative Code 28 Texas Administrative Code §134.401(c) (4) (B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed \$576.00 for revenue code 382-whole blood and \$142.50 for revenue code 390-blood/storage-processing. 28 Texas Administrative Code §133.307(g) (3) (D), requires the requestor to

provide “documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement.” Review of the explanation of benefits finds that the respondent reimbursed the requestor \$576.00 for revenue code 382 and \$142.50 for revenue code 390. No additional payment can be recommended.

- 28 Texas Administrative Code §134.401(c) (4) (C) states “Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time.” A review of the submitted itemized statement finds that the requestor billed \$272.00/unit for Gelfoam 100; \$329.00/unit for Vancomycin 1gr, and \$636.25 for Hespan 500 ml. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under Revenue Code 250. For that reason, reimbursement for these items cannot be recommended.
- 28 Texas Administrative Code §134.401(c) (4) (A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).” Review of the requestor’s medical bill finds that the following items were billed under revenue code 278 and are therefore eligible for separate payment under §134.401(c)(4)(A):

Charge code	Itemized Statement Description	Cost Invoice Description	UNITS / Cost Per Unit	Total Cost	Cost + 10%
81389991	Bone mtrx 5x5C	Acc tot bone matrix 5x5cm	1 @ \$1850	\$1850	\$2035
	Cncl crsh 30.0	Cancellous crushed 30cc	2 @ \$400	\$800	\$880
	DBM putty 10cc	Accell DBM 100 10cc	2 @ \$1495	\$2990	\$3289
	Infuse mdm kit	Infuse bone graft medium kit	2 billed; however invoice is for 1 only @ \$4490	\$4490	\$4939
	ILM strip 22x55	No invoice submitted	1	Na	Na
81952509	Wax bone 2.5 gr	Invoice submitted; however it is not legible	2	Na	Na
82402041	Imp sealnt pulm	No invoice submitted	1	Na	Na
Total allowable \$11,143.00					

The division concludes that the total allowable for this admission is \$5,590.00 per diem plus \$11,143.00 carve-outs for a total of \$16,733.00. The respondent issued payment in the amount of \$24,425.50. Based upon the documentation submitted, no additional reimbursement can be recommended.

### **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c) (1) titled *Standard Per Diem Amount* and §134.401(c) (4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

Signature	Medical Fee Dispute Resolution	April , 2013 Date
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Signature	Medical Fee Dispute Resolution	April , 2013 Date
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## **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**